STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A269	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Behavioral Health Center	3951 East Blvd. Los Angeles, CA 90066

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on interviews, observations and record reviews, the facility failed to follow its policy and procedures (P&P) titled, Abuse Prohibition Policy and Procedure dated 2/23/21. By failing to supervise Residents 1 and 2 while the resident were in the facility ' s staircase on 5/10/24. As a result, on 5/10/2024 at 10:40 AM Resident 2 pushed Resident 1 in the staircase, placing Resident 1 at risk for serious injury, harm, or death. Findings: A review of Resident 1 ' s Face Sheet indicated the resident was admitted to the facility on [DATE], with diagnoses that included paranoid schizophrenia (extremely disorganized or unusual behavior. This may show in several ways, from childlike silliness, delusions, hallucinations to being agitated for no reason). A review of Resident 1 ' s Minimum Data Set (MDS; a standardized assessment and care screening tool) dated 4/13/24, indicated Resident 1 had intact cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life). A review of Resident 1 ' s Care Plan dated 7/5/23, indicated Resident 1 exhibits symptoms of psychosis [a severe mental condition in which thought, and emotions are so affected that contact is lost with external reality] related to: perception disturbance and auditory hallucinations indicated interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) for facility staff to carry out included: monitor medical conditions that may contribute to psychosis; encourage resident to participate in special treatment programs; and maintain reality through reorientation. A review of Resident 1 ' s Care Plan dated 4/10/24 indicated, Resident 1 exhibits verbal behaviors related to: poor impulse control and schizophrenia indicated interventions for facility staff to carry out included: monitor medications and side effect; evaluate nature and circumstances of behaviors with resident; and offer psych/behavioral consultation as needed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s Care Plan dated 5/10/24 indicated, Resident with potential/risk to exhibit psycho-social distress related to alleged abuse indicated interventions for facility staff to carry out included: provide psychology/behavioral consult as tolerated; social services will provide monitoring for psychosocial distress/support; and mood/behavior monitoring. A review of Resident 1 ' s Progress Notes dated 5/10/24 at 12:11 PM indicated, At ~ (approximately)1040 this Resident (Resident 1) was observed in verbal argument with another female peer (Resident 2) as they were exiting the staircase. Resident 1 reported that female peer allegedly pushed her three times. A review of Resident 1 ' s Medication Administration Record (MAR) dated 5/1/24 to 5/31/24, indicated Resident 1 had episodes of labile (characterized by emotions that are easily aroused or freely expressed, and that tend to alter quickly and spontaneously; emotionally unstable) moods and suspicious behavior on consecutive days from 5/5/24 to 5/10/24. During an interview on 5/14/24 at 8:30 AM with Resident 1, Resident 1 stated, Resident 2 then told me You ' re a basketball player repeatedly. Then Program Coordinator (PC) said you go upstairs. Before that I told PC how she was disrupting the group. After that Resident 2 kept talking to me. I told her to stop talking to me. She pushed me. Then we were going up the stairs and got to the door of the stairwell and she pushed me three or four times. A review of Resident 2 ' s Face Sheet indicated the resident was admitted to the facility on [DATE], with diagnoses that included: paranoid schizophrenia (extremely disorganized or unusual behavior. This may show in several ways, from childlike silliness, delusions, hallucinations to being agitated for no reason). A review of Resident 2 ' s MDS dated [DATE], indicated Resident 2 was independent in performing activities of daily living (ADL ' s: activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). A review of Resident 2 ' s Care Plan dated 3/14/24 indicated, Resident 2 exhibits risk for distressed/fluctuating mood symptoms related to bipolar disorder as evidenced by expansive mood, excessive energy indicated interventions for facility staff to carry out included: encourage resident to participate in special treatment programs; allow time to express feelings; and programming staff to provide support. A review of Resident 2 ' s Care Plan dated 5/10/24 indicated, Resident exhibits physical behaviors towards peer related to poor impulse control indicated interventions for facility staff to carry out included: encourage evaluate need for psych/behavioral consult; seek staff support for distressed mood; remove resident from environment; and programming staff to provide support. A review of Resident 2 ' s Progress Notes dated 5/10/24 at 12:08 PM indicated, At ~1040 this Resident (Resident 2) was observed walking out of staircase door verbally arguing with female peer (Resident 1). Resident reported that she (Resident 2) allegedly pushed female peer (Resident 1) out of the way as she was blocking her from exiting. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2 ' s Progress Notes dated 5/10/24 at 1:08 PM indicated, reviewed incident report that occurred around 10:40 AM on 5/10/2024. This Resident was verbally disruptive in group continually speaking to female peer. Both were excused from group. Resident reports that while walking upstairs peer was blocking the door so she pushed peer out of the way. A review of Resident 2 ' s MAR dated 5/1/24 to 5/31/24, indicated Resident 2 had episodes of intrusiveness (being involved in a situation where you are not wanted or do not belong), lacking boundaries, disorganized thought process and being out of touch with reality on consecutive days from 5/6/24 to 5/10/24. During an interview on 5/14/24 at 9:00 AM with Resident 2, Resident 2 stated, I just made a comment to say that she ' s [Resident 1] tall do you play basketball and she got offended. She just got offended and we got upstairs. She stood by the door, and I thought she was threatening me. I just moved her out of the way. During an interview on 5/14/24 at 12:35 PM, the PC stated Resident 1 and Resident 2 get into an argument during a news group downstairs. The PC then excused Resident 1 and Resident 2 from the group and told the residents to go upstairs. PC stated, They were not supervised as they left, and both went up the stairs together back to their room. Then they got loud again at the top of the stairs. In hindsight they should have been supervised but I didn ' t expect them to go so quickly back to their rooms and I didn ' t expect for them to converge at the staircase. They should have been supervised. During an interview on 5/15/24 at 8:30 AM with CNA 2, CNA 2 stated that the stairwell was left unlocked at times without any staff assigned to supervise the stairs. CNA stated There is no specific person designated to supervise the stairs. After the programs end, they go four by four in the elevator upstairs. If there is space in the elevator a staff member will join in the elevator to supervise residents. They will go up the stairs if they don ' t want to wait. During an interview on 5/15/24 at 8:30 AM with CNA 3, CNA 3 stated, If a resident has behavior issues, we have to supervise them when they go upstairs. If there is an issue the counselor talks to them, and we monitor them every 15 minutes for three days minimum. If two residents are arguing they should not be allowed to go up the stairs unsupervised. The counselor should follow them up the stairs. They can start fighting if they are arguing downstairs in a group and go up the stairs unsupervised. During an interview on 5/15/24 at 11:02 AM with LVN 1, LVN 1 stated that he knew Resident 2 well and stated, a resident like her should not be allowed to use the stairway by themselves. They should be given counseling and redirection instead of being told to go upstairs if they behave badly during a group session. The consequences of not counseling and deescalating a resident that is acting out in a group are the agitation will continue and could escalate. In the process of going upstairs they could get into an altercation with another resident. In turn they can get harmed and might fall down the stairs. During an interview on 5/15/24 at 11:25 AM with LVN 2, LVN 2 stated, it is not safe for most of the residents here to go downstairs unsupervised, not even in the elevator because they have behavioral issues. I have seen them get into fights while in the elevator. The consequences of unsupervised residents going upstairs while agitated are an altercation, other residents may get involved and they can unexpectedly get harmed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/24 at 11:45 AM with CNA 1, CNA 1 stated, sometimes residents use the elevator unsupervised, if they don ' t want to wait, they use the stairwell. During an observation of the facility stairwell leading downstairs to the group activity area and elevator (elevator and stairs are next to each other), on 5/15/24 at 12:00 PM, approximately 3 residents were observed using the stairwell unsupervised and approximately 4 residents were observed using elevator unsupervised. During an observation of the facility stairwell leading downstairs to the group activity area and elevator (elevator and stairs are next to each other), on 5/15/24 at 12:10 PM, approximately 5 residents were observed using the stairwell unsupervised and approximately 3 residents were observed using elevator unsupervised. During an observation of the facility stairwell leading downstairs to the group activity area and elevator (elevator and stairs are next to each other), on 5/15/24 at 12:30 PM, approximately 10 residents were observed using the stairwell unsupervised and approximately 5 residents were observed using elevator unsupervised. During an interview on 5/15/24 at 1:05 PM with the Director of Nursing (DON), the DON stated, If two residents get verbal with each other in a group we separate them. We have three counselors there that would separate them. They would be escorted from the meeting by two different counselors and de-escalated. After they are separated, they are placed on q15 monitoring for 72 hours. It would not be appropriate for the counselor to allow them to go back to their room by themselves. They should stay with the resident and escort them. The consequences are they might fight each other and get injured. I have seen residents use elevators by themselves. They should not be allowed to use the elevator or stairway unsupervised for their safety. During an interview on 5/15/24 at 1:43 PM with the Administrator (ADM)/Abuse Coordinator (AC), ADM stated, If two residents get into a verbal altercation in a group, the staff would try to deescalate the situation. Sometimes if they are disrupting others, they are told to excuse themselves. They can go back upstairs, go to the TV room but not stay in the group because they are disturbing the other group members, the session. A review of the facility ' s P&P titled, Abuse Prohibition Policy and Procedure dated 2/23/21 indicated, Purpose: to prevent occurrences of abuse for all patients. Actions to prevent abuse including injuries: identifying, correcting, and intervening in situations in which abuse is more likely to occur. If the suspected abuse is resident to resident the center will provide adequate supervision when the risk of resident-to-resident altercation is suspected. The Center is responsible for identifying residents who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation. A review of the facility ' s P&P titled Supervision Level Protocol and Guidelines undated, indicated, The interdisciplinary team will continually evaluate the need for increased supervision of residents who present with cognitive, behavioral, medical, or other conditions that put them or others at risk. The team will provide increased levels of supervision as appropriate to ensure optimal resident safety and outcome.